

*Testimony before the Human Services Committee*

**H.B. No. 6367 AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET  
RECOMMENDATIONS FOR HUMAN SERVICES PROGRAMS**

*Roderick L. Bremby, Commissioner*

*February 26, 2013*

Good morning, Senator Slossberg, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Roderick Bremby and I am the Commissioner of Social Services. I appear before you today to testify on HB 6367, the Governor's Human Services Budget Implementer bill. I have already provided detailed testimony on the Governor's proposed budget to the Appropriations committee at last Friday's hearing, which many of you attended, therefore I will be highlighting only a few sections of particular interest today.

This bill includes additional strategies through which the Department of Social Services will be charged with aligning its Medicaid prior authorization practices and reimbursements over the biennium with various requirements of the December deficit mitigation package. Further, the bill seeks to enact enabling language in support of modernization of the Department's reimbursement methods. Additionally, the bill seeks to authorize certain administrative changes that the Department believes will be beneficial. Today I would like to highlight several sections of the bill that are of particular interest to the Department.

Sections 10 & 11 seek to enact enabling language to support the Department's hospital payment modernization project. The Department supports these sections as necessary preparatory steps toward equipping Medicaid to make payments based on reform strategies including, but not limited to, pay-for-performance (P4P), episodes of care and shared savings. These strategies will support both cost savings and a value-based orientation that rewards achievement of desired outcomes.

In brief, the elements necessary to support hospital payment reform include the following:

- 1) for inpatient payments: conversion from the current Target Payment/Discharge approach to use of Diagnosis Related Groups (DRGs);
- 2) for outpatient payments: conversion from the current mix of fixed fees and cost-to-charges ratios to Ambulatory Payment Classifications (APC); and
- 3) conversion of medical codes from ICD-9 to ICD-10.

A key aspect of hospital payment reform is conversion of methods for making inpatient and outpatient payments. Overall, conversion will align payments to the services that are provided,

incent efficiency, enhance predictability and transparency of method, accommodate value-based payment mechanisms (P4P, shared savings, episode bundling), and better align with methods used by private payers.

The Department plans to convert inpatient payments from the current Target Payment/Discharge approach to use of Diagnosis Related Groups (DRGs).

Under the current method:

- targets are based on 2007 data that is outmoded;
- payment is premised on average acuity, and may be undercompensating the actual costs of care; and
- settlement is required almost two years subsequent to payment;

DRGs (a prospective payment based on age, principle and secondary diagnoses and in some cases surgical procedure performed) will permit:

- Medicaid to establish “base rates” and “relative weights” for intensity of service; and
- outlier payments to accommodate higher acuity.

Further, the Department plans to convert outpatient payment from the current mix of fixed fees and cost-to-charge ratios to Ambulatory Payment Classifications because:

- the current method is based on Medicare cost reports that are perennially dated; and
- APCs (a prospective payment based on service(s) provided) will permit Medicaid to establish “base rates” and “relative weights” for intensity of service.

Another necessary element of payment modernization is the required conversion of medical code sets. Effective October 1, 2014, all providers that are HIPAA-covered entities will be required to convert from the current ICD-9 medical code set to the updated ICD-10 set. ICD refers to the International Classification of Diseases, Tenth Revision, Procedure Coding System. This change impacts every facet of America’s health care systems, not just Medicaid, and will bring the U.S. on to a coding system used in the rest of the health care world since the 1990s. ICD-10 involves both modifications to code groupings (taxonomy) and doubling of the number of codes, representing a much higher degree of specificity (e.g. ICD-9 provided a code for a burn; ICD-10 provides a series of codes for burns based on where the burn is located on the body, its severity, and how it occurred). These codes are currently used in MMIS, provider contracts, client plan and other insurance rules, reimbursement rules and prior authorization.

Sections 10 & 11 provide the statutory framework needed to support the Department's work in these related activities.

The Department also supports the intent of sections 27 - 31 in integrating the Behavioral Health Partnership (BHP) Oversight Council into the Medical Assistance Program Oversight Council (MAPOC). While the Department applauds the work of the BHP Oversight Council in helping to steward transition of Medicaid behavioral health services to an Administrative Services

Organization (ASO) model and in providing ongoing review and comment, the Department strongly supports integration of services and supports, as well as administrative oversight of Medicaid medical, behavioral and long-term services and supports.

Many Medicaid beneficiaries, especially those who are dually eligible for Medicare and Medicaid, have complex health profiles. A high incidence of beneficiaries have co-morbid physical and behavioral health conditions, and need support in developing goal-oriented, person-centered plans of care that are realistic and incorporate chronic disease self-management strategies. A siloed approach to care for a recipient's medical and behavioral health needs is unlikely to effectively care for either set of needs. For example, a client with depression and a chronic illness such as diabetes is unlikely to be able to manage either diabetes or depression without effectively addressing both conditions. The Department has recognized the need for integration of these services and supports through diverse strategies including partnership between its medical and behavioral health ASOs, planning for a demonstration in support of the needs of individuals who are dually eligible for Medicare and Medicaid, and through its Strategic Rebalancing Plan. Integrating the work of the BHP Oversight Council within MAPOC would model the Department's strategies.

The Department also supports integration of the BHP Oversight Council within MAPOC for reasons of streamlining and improving the often parallel work of the committees associated with both groups. Two of the associated committees (the MAPOC Consumer Access Committee and the BHP Coordination of Care Committee), both of which focus on access to services, have already recognized the potential for duplication of effort and have agreed informally to coordinate. This practice would be furthered by explicitly including behavioral health within the scope of MAPOC's work and reviewing and revising the charge of its committees correspondingly. It would also permit the Department to focus the efforts of identified staff liaisons to the committees, support clear and consistent communication and optimize sharing of information.